

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05696

92d

Reg. Dist. No. 2-03

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
life
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jessie Cooper Ashley

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife George Ashley
living 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 8, 1872
 8. AGE: Years 76 Months I Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Kent Co., Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Harrison E. Cooper
 13. Birthplace Delaware
 14. Maiden name Elizabeth Ivens
 15. Birthplace Penna.

16. Informant Mrs. Sewell Lee (Sister)
 Address Worton, Md.
 17. Burial Date thereof May 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory CHESTER CEM.
 Location CHESTERTOWN, Md
 18. Funeral director J. Willis Wells
 Address Chestertown, Md.
 19. 5/15 48 5. Elwood Bingham
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1948 at 1:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/14/48 11:45 PM to 7/15/48 1:30 PM
 and that I last saw him alive on 7/14 1948

Immediate cause of death known Ex. Docentific
cardiac & pulmonary
coronary thrombosis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Albert G. Bingham M. D. or other _____
Rock Hall, Md Address _____ Date signed 7/15/48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05097

50

Reg. Dist. No. 2.02

1. PLACE OF DEATH:

County KentCity or town Chaptain
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.Hospital, institution, or street address where death occurred:
112 N. Queen

How long in hospital or institution?

3. (a) FULL NAME

Marian E. Bunn

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Chaptain
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 N. Queen
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

J. Lewis Bunn

7. Birth date of deceased (mo., day, yr.)

February 1, 18936. (c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

58324

hrs.

min.

9. Birthplace

Campbell New York
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

MOTHER FATHER

12. Name

Charles H. Woodward

13. Birthplace

Wagon New York

14. Maiden name

Narritt Bunn

15. Birthplace

Campbell New York

16. Informant

Mr. J. Lewis Bunn (husband)

Address

112 N. Queen St Chaptain Md

17.

(Burial, cremation, or removal Which?)

Date thereof

May 26, 1948
(month) (day) (year)

Cemetery or crematory

Campbell - Hope Cemetery

Location

Campbell, New York

18. Funeral director

Martin V. Williams

Address

Chaptain Maryland

19.

(Date read by registrar)

May 24, 1948Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1948 at 6:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1948 to May 22 1948
and that I last saw him alive on May 22 1948

Immediate cause of death

Secondary Quinse

Due to

Causes of MeaslesMeaslesDue to Measles

Other conditions

Measles

(Include pregnancy within 3 months of death)

Major findings of operations

Severely InflamedDate of op. 4/4

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles H. Woodward M. D. or other
Address Chaptain Md Date signed May 23/48

DURATION

1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year1 year



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

05098

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Kentland Green Acres Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Green Acres
 City or town Rural Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Jessie Burke

3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife Blanche E. Anderson
 6. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) 8-3-1881

8. AGE: Years 66 Months 9 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Centerville, Pa. Co., Md.
 (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business _____

12. Name Bill Burke

13. Birthplace Green Acres Co., Md.

14. Maiden name Rachael Huett

15. Birthplace Green Acres Co., Md.

16. Informant Hosp. records

Address 1 Ches. Br. town Md

17. Burial Date thereof May 20-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chestertown

Location Centerville Md.

18. Funeral director Southern & Perry

Address Centerville Md.

19. May 18 1948 Clara S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 15 1948 to MAY 18 1948
 and that I last saw him alive on MAY 18 1948

Immediate cause of death Peripheral circulatory collapse DURATION 20 min.

Due to Paralytic ileus 3 days

Due to Operation for intestinal obstruction 3 days
5 days

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Intestinal obstruction due to strangulated umbilical hernia Date of op. May 16, 1948

Autopsy results unified hernia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. P. Dick, M.D. M. D. or other _____

Address Chestertown, Md. Date signed 5-18-48

Allen Barnes

Frank Smith

1881-8-3
66-9-150
1948-8-18
7-1-2

RECEIVED
MAY 20 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 205

1. PLACE OF DEATH:

County Kent
 City or town Chestertown - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 years
 Hospital, institution, or street address where death occurred:
Kent County Almshouse
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chestertown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Kent County Almshouse
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Carroll

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Unknown
 7. Birth date of deceased (mo., day, yr.) (unknown) 1871 6.(c) If alive, give age _____ years
 8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.

8. Birthplace Church Hill, Queen Anne's Co., Maryland
(Town, county, and state)10. Usual occupation House servant

11. Industry or business _____

FATHER 12. Name Unknown
 13. Birthplace _____

MOTHER 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Mr. J. B. Sutton
 Address Chestertown, Md.

17. Burial Burial Date thereof May 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory cemetery
 Location Kent County Almshouse

18. Funeral director Mr. J. B. Sutton
 Address Chestertown, Md.

19. May 27 1948 Class L. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1948 at 11:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth 1947 to May 27 1948
 and that I last saw him alive on May 27 1948

Immediate cause of death Probable cerebral intra
cerebral hemorrhage DURATION 15 minutes

Due to Cerebral arterio-sclerosis unknown

Due to _____

Other conditions Had mastectomy for carcinoma in May 1945. no evidence of metastasis
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

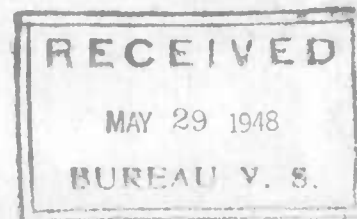
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Jan M. D. Jan

Address Chestertown, Md. Date signed 5-27-48

1948
8761
177
187



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: Kent
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 Washington Ave
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland..... County..... Kent.....
 City or town..... Chestertown.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

James W. Crouch

3. (b) Social Security Number

220-OI-7023A

4. Sex..... Male.....
 5. Color or race..... white.....
 6. (a) Single, married, widowed, or divorced..... married.....
 8. (b) Name of husband or wife..... Bertha S. Crouch.....
 living.....
 7. Birth date of deceased (mo., day, yr.)..... Oct. 17, 1867.....
 8. AGE: Years..... 80..... Months..... 6..... Days..... 15.....
 If less than one day..... hrs. min.

9. Birthplace..... Kent CO. Maryland.....
 (Town, county, and state)

10. Usual occupation..... Bank Teller.....

11. Industry or business

12. Name..... Wm. A. Crouch.....
 13. Birthplace..... Maryland.....

14. Maiden name..... Annie Ireland.....
 15. Birthplace..... Md.....

16. Informant..... Mrs. Bertha S. Crouch.....
 Address..... Chestertown, Md.....

17. Burial..... Date thereof..... May 4, 1948.....
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Chester Cem.....
 Location..... Chestertown, Md.....

18. Funeral director..... J. Willis Wells.....
 Address..... Chestertown, Md.....

19. May 3, 1948..... Date of death by registrar.....
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2, 1948, at 9 A.M.....

21. CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 1947, to..... May 2, 1948,
 and that I last saw him alive on..... May 1, 1948.

Immediate cause of death.....
 Cardiac insufficiency.....
 Due to..... Cardiac dilatation.....
 DURATION..... 2 mo

Due to.....
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

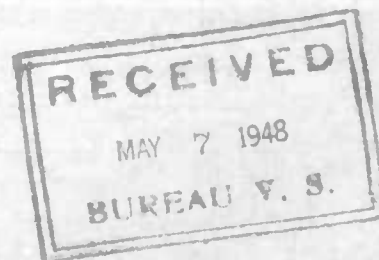
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....
 M. D. or other.....
 Address.....
 Date signed.....



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall (Piney Neck)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
R.F.D.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Piney Neck
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mildred Amelia Frazier

3. (b) Social Security Number

no

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Oliver E. Frazier

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 10, 1877

8. AGE: Years 70 Months 10 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Conn.
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Wm. A. Baldwin13. Birthplace Conn.14. Maiden name Martha J. Swindells15. Birthplace Maryland16. Informant Oliver E. Frazier, Jr.Address Rock Hall, Md.17. Burial Date thereof May 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesley ChapelLocation near - Rock Hall, Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.19. May 6 19 48 S. Elmer Burgess
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 4 19 48, at 2:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to May 4 19 48 and that I last saw her alive on May 4 19 48Immediate cause of death Deep fatal arteriosclerosis with gangrene DURATION 6 yrs

Due to _____

Due to Cardiac Insufficiency
Arrhythmia

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank N. Smith M. D. or other _____Address Chestertown Date signed May 6

RECEIVED

MAY 8 1948

BUREAU V. S.

05102

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Kent and Queen Anne's
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County QUEEN ANNE
 City or town Rural - Chestertown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

TIMOTHY FISHER
DAVE RAY LEVERAGE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife none
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 27, 1948
 8. AGE: Years _____ Months _____ Days 4 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 1 19 48, at 5:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 48 to MAY 1 19 48
 and that I last saw him alive on April 30 19 48
 Immediate cause of death SUFFOCATION
 DURATION _____

9. Birthplace Chestertown, Kent, Maryland
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business _____
 12. Name William Edwin Leverage
 13. Birthplace (near) Chestertown, Maryland
 14. Maiden name Grady's Roberta Storey
 15. Birthplace Millington, Maryland
 16. Informant Hospital Records
 Address Chestertown, Md.
 17. Burial Date thereof May 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Church Hill Cem.
 Location Church Hill-Queen Anne Co., Md.
 18. Funeral director J. Willis Wells
 Address Chestertown, Md.
 19. May 1 19 48 Clara S. Barnes
 (Date read by registrar) Registrar

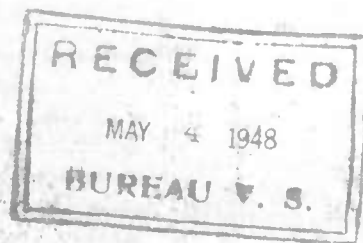
Due to Aspirated mucus
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE A.C. Dick, M.D.
 Address Chestertown, Md. Date signed 5-1-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and fully.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05103

Reg. Dist. No. 280

1. PLACE OF DEATH:

County Sassafras, md.
 City or town Sassafras md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6.9 years.
 Hospital, institution, or street address where death occurred: -
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Sent.
 City or town Sassafras, md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Mentie Pennicks
 4. Sex F. 5. Color or race C 6.(a) Single, married, widowed, or divorced widowed

3. (b) Social Security Number

6.(b) Name of husband or wife -
 6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) -
 8. AGE: Years Months Days If less than one day
69-1878 hrs. min.

9. Birthplace Sassafras md
 (town, county, and state)

10. Usual occupation house work.

11. Industry or business -

12. Name unknown

13. Birthplace -

14. Maiden name Sasha Brown

15. Birthplace Sassafras md

16. Informant Annie Ringe

Address Sassafras md

17. Sassafras Date thereof May 29, 1948
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Sassafras, md

Location Sassafras

18. Funeral director Arthur O. Caulk

Address 827 Pine St.

19. May 26 19 48 Edward H. Thomas
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 48 at 5452 N.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 47 to May 24 19 48

and that I last saw him alive on May 24 19 48

Immediate cause of death nephritis acute

② generalized arterio-

sclerosis

③ arteriosclerotic

heart disease

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

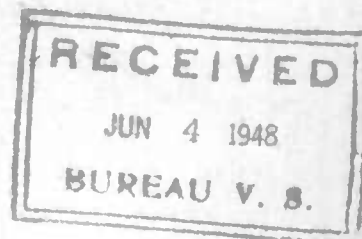
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas J. Paprocki MD

Address Galeton, Md Date signed 5-25-48

DURATION
3 days
20 yrs
10 yrs



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County ChesapeakeCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 19 days

3. (a) FULL NAME

Robert Franklin Rouse

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 18, 1868

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

79629

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Address

17. (Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16, 1948, at 1:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 29, 1948, to May 16, 1948

and that I last saw him alive on

May 16, 1948

Immediate cause of death

Malnutrition

Due to

Chronic myocarditis

Due to

Intoxication

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul H. RouseAddress Chesapeake, Md.

M. D. or other

Date signed May 18, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 200

1. PLACE OF DEATH:

County Kent
 City or town Millington
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 4 yearsHospital, institution, or street address where death occurred: King's nursing HomeHow long in hospital or institution? about 2 yrs.

3. (a) FULL NAME

Irene Stephens

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 18, 1887
 6. (c) If alive, give age _____ years

8. AGE:

Years 66 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace

Penn.

10. Usual occupation

Housework

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown

16. Informant

Mrs. Genevieve WalshAddress Millington Md.17. Burial (Burial, cremation, or removal. Which?)Dale thereof May 5, 1948Cemetery or crematory Rembleville Mc. CountyLocation Rembleville Md.

18. Funeral director

Edward FellowsAddress Millington Md.19. May 4 19 48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.City or town Salina

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

22002

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 48, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8 19 47 to May 1 19 48and that I last saw him or alive on May 1 19 48Immediate cause of death Stroke

DURATION

Due to Arteriosclerosis heart diseaseDue to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 2 Date of _____Where did injury occur? Home

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. H. Hamilton

M. D. or other

Address MillingtonDate signed May 4/48

RECEIVED

MAY 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

05106

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County 1 CentCity or town Rural Galva
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County New CastleCity or town Middletown Del.
(If outside city or town limits, write RURAL and give nearest town)Street No. World war II
(If rural, give LOCATION)2(a) If veteran, name war World war II ✓

3. (a) FULL NAME

Clementa Martin Waters

3. (b) Social Security Number

Lost

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

MEDICAL CERTIFICATION

8.15^P2D. DATE OF DEATH May 19 19 48 at 4:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

No medical attentionand that I last saw him alive on May 19 19 48Immediate cause of death Patton J. MedicalExamination:

DURATION

Due to Bullet wounds of head neckand arms.Due to Fatal wound under earfrom 22. pistol shot.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 5/19/48

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Pistol shot Injured at work?23. SIGNATURE Laurel W. Smith

M. D. or other

Address Chesutown RR Date signed May 20/48

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 26, 1923

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

25

hrs.

min.

9. Birthplace

Middletown Del.
(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Construction Work

MOTHER FATHER

12. Name

Alfred Waters

13. Birthplace

Middletown Del.

14. Maiden name

Loleta Caulk

15. Birthplace

Middletown Del.

16. Informant

Loleta Caulk

Address

Middletown Del.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 24/48

Cemetery or crematory

Valley Bur.

Location

Middletown Del.

18. Funeral director

Edward McElwain

Address

Middletown Del.

19. May 20

(Date rec'd by registrar)

19 48Elzabeth J. Neff

Registrar

RECEIVED

JUN 4 1948

BUREAU V. S.